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THE AARP ADS AND THE NEW MEDICARE PRESCRIPTION DRUG LAW

by Edwin Park and Robert Greenstein

On December 2, 2003, the AARP began running advertisements in national newspapers citing eight benefits of the final Medicare legislation that the President signed into law on December 8. The ad's headline states that the ad contains "no sound bites... no spin.... no politics... just the facts."

The following is an analysis of the ad's claims.¹ It should be noted that some of the problematic aspects of the legislation that relate to low-income Medicare beneficiaries and the premium support demonstration, which are described below, would have been more problematic without AARP's use of its influence to soften the adverse effects of those provisions.

- **AARP Claim:** "[The Medicare bill] protects traditional Medicare. Nothing in the legislation undermines traditional fee-for-service Medicare. And anyone can stay in it if they choose."

Analysis: This claim is open to debate. Under the Medicare program, beneficiaries can elect to receive all of their Medicare benefits, including the new drug benefit, from private managed care plans (primarily HMOs) rather than through traditional Medicare fee-for-service. The Medicare legislation increases payments to these private managed care plans by more than \$14 billion, despite the fact that the Medicare Payment Advisory Commission (MedPAC), a nonpartisan organization established by Congress to analyze Medicare payment policies, has found that private plans already are reimbursed at rates 19 percent higher than traditional Medicare pays.² Under the legislation, these private plans — principally HMOs — will be reimbursed at rates approximately 25 percent higher than traditional Medicare.

Private managed care plans will be able to use these extra payments to offer more generous drug coverage, as well as other benefits that traditional Medicare does not cover, to induce more Medicare beneficiaries — especially those who are healthier — to opt out of traditional fee-for-service and enroll in these private plans.

¹ For an overview of some of the problematic aspects of the final Medicare legislation, see: Edwin Park, Melanie Nathanson, Robert Greenstein and John Springer, "The Troubling Medicare Legislation," Center on Budget and Policy Priorities, revised December 8, 2003; and Jeanne Lambrew, "Lost in the Fine Print: Ten Overlooked Policies That Harm Medicare and Its Beneficiaries," Center for American Progress, December 4, 2003.

² Congressional Budget Office, "Cost Estimate for H.R. 1, Medicare Prescription Drug, Improvement, and Modernization Act of 2003", November 20, 2003; Transcript of the Medicare Payment Advisory Commission Public Meeting, October 9, 2003; Medicare Payment Advisory Commission, "Meeting Brief: Medicare+Choice Payment and Eligibility Policy," December 4-5, 2003.

Consider how this may play out with regard to drug coverage. Under the legislation, the Medicare drug benefit will provide no coverage for a beneficiary's total drug costs in excess of \$2,250 a year, until the beneficiary's drug costs exceed \$5,100.³ The legislation also prohibits a beneficiary who has Medicare drug coverage from purchasing a supplemental "Medigap" insurance policy that covers drug costs in this coverage gap (or that covers any other drug costs the Medicare drug benefit does not cover). As a result, there will generally be only one way for most beneficiaries to secure coverage for drug costs in this coverage gap: by giving up their choice of doctors and enrolling in a managed care plan that uses the generous federal subsidies it receives — and the fact that it may be able to attract healthier-than-average beneficiaries and thereby reduce its per-enrollee costs — to offer drug coverage that fills some of the gaps. In other words, the legislation tilts the playing field in favor of private managed care plans and, as a consequence, is likely to drive many beneficiaries who otherwise wish to remain in traditional Medicare so that they can retain their choice of doctors to switch to managed care plans to secure more adequate drug coverage (as well as other expanded benefits the private plans may offer).

For these reasons, in analyzing the House version of the Medicare legislation — which would have provided *smaller* subsidies to private plans than the final legislation does — the actuaries at the Centers for Medicare and Medicaid Services estimated that the proportion of Medicare beneficiaries enrolled in private managed care plans instead of traditional Medicare would rise from less than 15 percent of beneficiaries today to more than 40 percent by 2010.⁴ The provisions of the new law which confer very generous federal subsidies on private managed care plans — and thereby enable those plans to lure more beneficiaries away from traditional Medicare — may present a danger over time to the survival of fee-for-service Medicare.

The legislation's decided tilt toward private managed care plans also will lay a foundation for the premium support demonstration that will start in 2010. Under the demonstration, traditional Medicare will be forced to compete directly with these private managed care plans in six metropolitan areas. Under the demonstration, a benchmark cost will be established for each geographical area. If the local costs-per-beneficiary of Medicare fee-for-service (or of the private plans) exceed the benchmark, those enrolled in that form of Medicare will be charged increased premiums to cover the difference. (The extra subsidies will not be counted when measuring the per-beneficiary costs under the private managed care plans.) Because beneficiaries who remain in traditional fee-for-service Medicare are likely to be older and sicker on average than those who enroll in the private plans, the cost per beneficiary of fee-for-service Medicare is likely to exceed the

³ Total drug costs include both the portion of a beneficiary's drug costs that Medicare covers and the portion that the beneficiary must pay. Under the formula in the new law, when a beneficiary's total drug costs reach the \$5,100 level — the level at which drug coverage resumes — the beneficiary will have paid \$3,600 out-of-pocket and Medicare will have paid \$1,500.

⁴ Memorandum from Richard Foster, Office of the Actuary, Centers for Medicare and Medicaid Services to Representative Charles Rangel, June 26, 2003.

benchmark, causing premiums for fee-for-service Medicare to rise over time⁵ and thereby inducing still larger numbers of beneficiaries to switch out of traditional Medicare into the private managed care plans.

The new law also risks weakening Medicare financing by manufacturing an artificial Medicare financing crisis. The legislation creates a presumption that no more than 45 percent of Medicare's costs should come from general revenues, even though Medicare Part B (which pays for physician and other outpatient services) and the new drug benefit are *supposed to be* financed through general revenues. The new law calls for the issuance of official government reports every year that identify the year in which the 45-percent threshold will be reached and that indicate the magnitude of the "unfunded liability" of the Medicare program as a whole. The new law mandates that this "unfunded liability" be computed based on the assumption that general revenues *cannot* defray more than 45 percent of overall Medicare costs. This provision of the new law also requires the consideration of legislation to make changes in Medicare that would keep general revenues from covering more than 45 percent of costs.

These official reports will convey the impression that the entire Medicare program will become insolvent in the near future. Yet federal law does *not* limit general revenue financing to 45 percent of total program costs. Moreover, the parts of Medicare that are financed with general revenues — physician and outpatient services and prescription drugs — no more face insolvency than do other parts of the federal budget that are financed with general revenues, such as the Defense Department or veterans programs. This aspect of the new law may create a crisis atmosphere in which more radical changes in Medicare can be considered.

In addition, by erecting a standard that general revenue financing should not exceed 45 percent of total program costs, the new law creates a presumption that income tax reforms that increase revenues should not be used to cover rising Medicare costs, since that would constitute an increase in general-revenue financing. That leaves cuts in Medicare services, increases in the premium, deductible and cost-sharing amounts that beneficiaries are charged, reductions in payments to providers, and increases in regressive payroll taxes as the only options consistent with the 45-percent standard.⁶

It is unclear what long-term effect this "cost containment" provision will have, but the provision certainly poses some danger to the program. When this provision is considered in combination with the provisions that tilt toward private managed care plans and create an unlevel playing field to the detriment of traditional fee-for-service Medicare, it leads to a conclusion that the AARP pronouncement that "nothing in the legislation undermines traditional fee-for-service Medicare" is open to serious question.

⁵ Under the premium-support demonstration project, the premium increases for fee-for-service beneficiaries which result from the comparison of fee-for-service costs to the benchmark are capped at five percent per year. These increases would be in addition to the premium increases that otherwise occur due to normal increases in Medicare costs. Beneficiaries with income below 150 percent of the poverty line will be exempt from the premium increases that result from these benchmark comparisons.

⁶ See Richard Kogan, Edwin Park and Robert Greenstein, "Medicare 'Cost Containment' Proposal Includes Ideologically Loaded Provisions," Center on Budget and Policy Priorities, revised November 7, 2003.

- **AARP Claim:** “It helps those who need it most. The new benefit provides for comprehensive drug coverage for people with low incomes, at virtually no cost to them.”

Analysis: Many low-income Medicare beneficiaries who do not qualify for Medicaid will receive substantial assistance under the legislation. But several million of the nation’s poorest elderly and disabled beneficiaries will be made *worse off* by the new legislation, because they will have to pay more for drugs than they currently pay under Medicaid, will be denied coverage for some drugs they currently receive through Medicaid, or both.

Under current law, if a benefit is covered by both Medicare and Medicaid, Medicare pays first and Medicaid supplements that coverage, filling in gaps and picking up some or all of the remaining cost-sharing charges. Maintaining that structure, which has characterized the relationship between Medicare and Medicaid for 35 years, would have ensured that low-income beneficiaries who currently receive drug coverage through Medicaid but whose drug coverage will be shifted to Medicare under the new law would *not* be made worse off. The Medicare legislation, however, abandons the longstanding relationship between Medicare and Medicaid and specifically *prohibits* Medicaid from playing its normal role and supplementing (or “wrapping around”) the Medicare drug benefit.

As a result, the Medicare legislation will require several million of the poorest and most vulnerable Medicare beneficiaries to pay higher co-payments than they currently pay through Medicaid.⁷ Medicaid beneficiaries currently receive prescription drugs free of charge or pay charges that are generally limited to no more than \$1 or \$2 per prescription per month. Under the new legislation, elderly and disabled Medicare beneficiaries who qualify for Medicaid and have gross incomes modestly above the poverty line will begin paying charges of \$5 per month per brand-name prescription and \$2 per month per generic prescription. (The charges are lower for those below the poverty line.) For those with few prescriptions, these differences may not matter much. For those with many prescriptions, however, the differences can be significant.

Of particular concern, these \$5 and \$2 charges will be increased each year by the percentage that *drug costs rise per Medicare beneficiary*, which the Congressional Budget Office projects will be about 10 percent per year. These near-poor elderly and disabled beneficiaries live primarily on fixed incomes that do not rise over time or on small Social Security checks that rise with the general inflation rate, which CBO projects will be about 2.5 percent per year. In other words, the drug co-payment charges these beneficiaries will have to pay will rise about *four times faster* than their incomes. This is likely to make the co-payments increasingly unaffordable over time for some beneficiaries with a substantial number of prescriptions. This matter is of particular concern because the elderly and disabled people with gross incomes over 100 percent of poverty line who qualify for Medicaid — the group that will be most adversely affected

⁷ See Edwin Park and Robert Greenstein, “Medicare Agreement Would Make Substantial Numbers of Seniors and People with Disabilities Worse Off Than Under Current Law,” Center on Budget and Policy Priorities, revised November 21, 2003.

—are primarily people with serious medical conditions who have sufficiently high out-of-pocket medical costs that their *disposable* incomes end up below the poverty line.

Still more troubling, Medicaid generally covers all drugs that a beneficiary needs. By contrast, the new legislation allows the private insurance plans that will deliver the Medicare drug benefit to beneficiaries in Medicare fee-for-service (as well as HMOs and PPOs that provide all Medicare benefits to their enrollees, including the drug benefit) to limit coverage to two drugs per therapeutic class. This means that many poor elderly and disabled beneficiaries who currently receive drug coverage through Medicaid may *lose* coverage for the drugs they have been prescribed.

In short, several million of “those who need it most” will be harmed rather than helped by the legislation. (This problem would have been worse if AARP had not used its influence in the final days of conference negotiations to secure changes that made the adverse effects of the legislation on low-income beneficiaries enrolled in both Medicare and Medicaid less severe than they otherwise would have been.)

- **AARP Claim:** “It protects those with the highest drug costs. For those with very high drug bills, the federal government will pay for 95% of their prescription drug costs.”

Analysis: Those with the highest drug costs will get *partial* protection. Depending on the beneficiary and the private insurance or managed care plan in which the beneficiary is enrolled, the protection may be much more limited than may first meet the eye.

This AARP claim refers to the fact that under the legislation, Medicare will cover 95 percent of the drug costs that a beneficiary receives *after* a beneficiary incurs \$5,100 in total drug costs (and \$3,600 in out-of-pocket costs; see footnote 3). Coverage stops after the first \$2,250 a year in total drug costs. There is no coverage for drug costs incurred after the first \$2,250 in costs until total drug costs (including the share that Medicare pays of the first \$2,250 in costs) reach \$5,100.

Of particular importance, the private plans that administer the drug benefit will be allowed to limit the prescription drugs they cover. As noted, these private plans will not be required to cover more than two drugs per “therapeutic class.” Many drugs that doctors prescribe as being the most appropriate for a patient may not be covered. If a beneficiary purchases drugs that have been prescribed by his or her doctor but that the private plan does not cover, the cost of purchasing such drugs *does not count* toward the \$5,100 threshold that a beneficiary’s drug costs must reach before coverage for 95 percent of remaining drug costs kicks in. Furthermore, the coverage that applies after the \$5,100 threshold is reached applies *only* to those drugs that the private plan covers; there continues to be *no* coverage for other drugs a beneficiary’s doctor may prescribe.

- **AARP Claim:** “All Medicare beneficiaries will have access to drug coverage. This is a guaranteed drug plan for all beneficiaries, regardless of where they live.”

Analysis: The specific drug coverage offered is likely to vary substantially across the country. The new legislation allows the private insurance plans that will deliver the new

Medicare drug benefit to beneficiaries in fee-for-service Medicare —as well as the private managed care plans that will deliver all Medicare benefits to their enrollees — to vary the Medicare drug benefit substantially so long as they provide a benefit judged to be at least equivalent in overall value to the so-called standard Medicare drug benefit. Within some limits, the premium charges, deductibles, cost-sharing and coverage gaps can differ from plan to plan; the new law allows the private plans — rather than Medicare — to set the premium and other charges for the Medicare drug benefit.

In addition, each private plan will decide which drugs to cover. As noted, the sole requirement is that each private plan must cover at least two drugs per therapeutic class. The private plans will have discretion to determine how such classes are defined and which drugs within these classes they will cover. The private plans will even be permitted to alter the list of drugs they cover during the course of the year — and to drop various drugs during the year — despite the fact that beneficiaries will be allowed to switch plans only once a year. It may be noted that in determining which drugs to cover, some private plans are likely to make decisions with an eye to discouraging some beneficiaries with very high drug costs from enrolling in their plan.

In short, drug coverage will vary. Where beneficiaries live will have a considerable effect in determining the specific drug benefit they receive.

- **AARP Claim:** “This new drug benefit is voluntary. People can elect to keep any existing coverage they have, and no one will be forced to enroll in the new program.”

Analysis: The statement that “people can elect to keep any existing coverage they have” is not correct. Low-income Medicare beneficiaries eligible for Medicaid will no longer be able to receive drug coverage through Medicaid. Their only alternative will be to enroll in the new Medicare drug benefit, even though as described above, in most cases they will have to pay higher co-payments and may lose access to certain drugs they currently can obtain through Medicaid. Similarly, some beneficiaries who currently receive more generous retiree drug coverage through their former employers will have no alternative but to receive more restrictive drug coverage through the new Medicare drug benefit if their employers drop coverage. Many beneficiaries who currently receive their coverage through state-funded pharmacy assistance programs will similarly lose such coverage if their states eliminate such programs as a result of the establishment of the Medicare drug benefit.

- **AARP Claim:** “It protects retiree coverage. The legislation provides incentives for employers (both public and private) so that people who already have good private coverage will not lose it.”

Analysis: The legislation does include substantial subsidies to encourage employers to maintain drug coverage for retirees. Even with these subsidies, however, the Congressional Budget Office projects that 2.7 million retirees are expected to lose the drug coverage they currently receive through their former employers — which typically is more extensive than the limited coverage the new Medicare drug benefit provides —

because their employers will drop such coverage when the Medicare drug benefit becomes available.⁸

⁸ Congressional Budget Office, “Letter to the Honorable Don Nickles Providing Additional Information about CBO’s Cost Estimate for the Conference Agreement on H.R. 1”, November 20, 2003.